Module 8: Reporting & Data Tracking

Executive Summary

Transform data from a daunting requirement into a powerful tool! This module will demystify the essential processes of screening, assessment and data documentation, empowering you to accurately track client progress and demonstrate your program's impact. Learn how to navigate reporting requirements, ensure data integrity and leverage data to refine your service goals and effectively support family needs.

Topics:

- ☐ Data Collection & Management
- ☐ Client Service & Program Implementation
- ☐ Reporting & Compliance

Resources Needed:

- ☐ Community Needs Assessment
- ☐ Organization's Goals

Recommended Staff:

- ☐ Home Visiting Program Manager(s)
- ☐ Grants Manager

▶ Data Collection & Management | 8.1

Learning Objective: Participants will be able to detail their organization's systems for screening, assessment, documentation, needs support tracking and service goal tracking.

Data is key to your organization's success; it demonstrates your capacity to implement your program effectively and measure your impact. This section focuses on the essential foundation of evidence-based practice: robust data collection and management. It's important to note that organizations use a variety of tracking systems; however, THV requires that you adhere to all state and program requirements and demonstrate that you respect client data. This is your opportunity to show a clear plan for how you will screen families, assess their needs, document services, track progress towards goals and provide needs support. A well-articulated data management plan builds confidence in your program's ability to achieve its intended outcomes and fulfill reporting requirements.

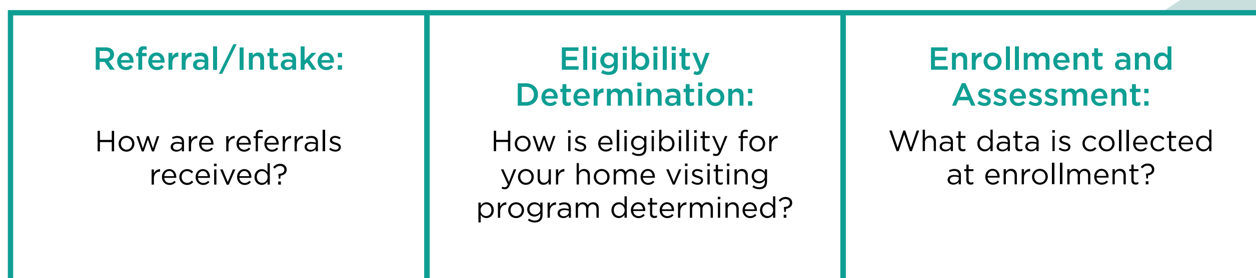
In this section, we'll review how you will track client progress toward service goals and document the provision of basic needs support. The goal is to prove you have a systematic and organized approach to measuring impact.

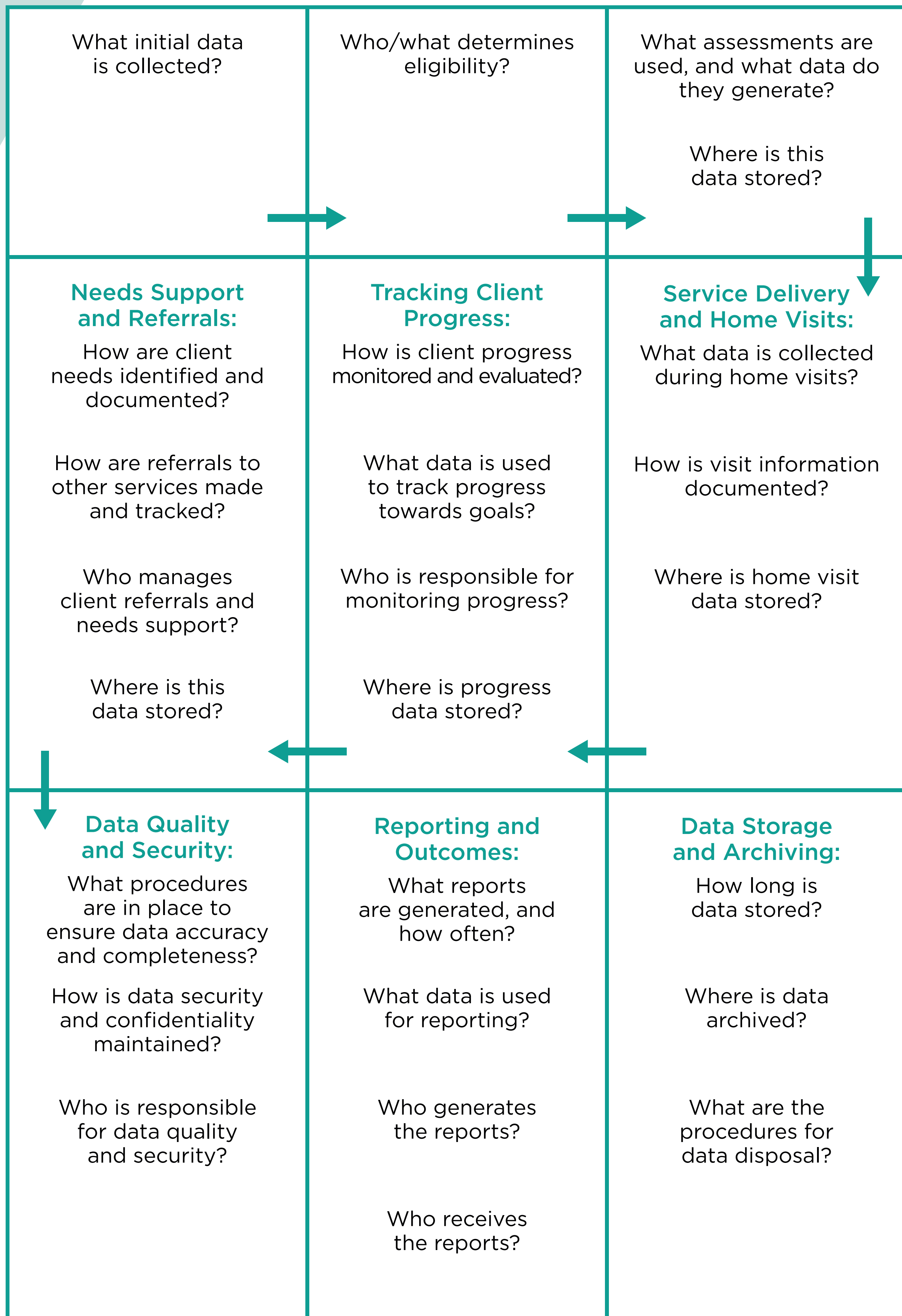
☐ Activity 1: Mapping Your Data Flow

Effective data collection and management are essential for home visiting programs to track progress, demonstrate outcomes and ensure accountability. This activity will guide you in creating a visual representation of your data collection and management processes. By mapping out your data flow, from initial screening to tracking client progress and providing needs support, you'll gain a clearer understanding of your data systems and be well-prepared to articulate this process in your application narrative.

Instructions:

1. Complete the visual flowchart of your organization's data flow for your home visiting program.
2. Try to answer as many of the questions applicable to your program.




What initial data is collected?
Who/what determines eligibility?
What assessments are used, and what data do they generate?
Where is this data stored?
Service Delivery and Home Visits:
What data is collected during home visits?
How is visit information documented?
Where is home visit data stored?
Tracking Client Progress:
How is client progress monitored and evaluated?
What data is used to track progress towards goals?
Who is responsible for monitoring progress?
Where is progress data stored?
Needs Support and Referrals:
How are client needs identified and documented?
How are referrals to other services made and tracked?
Who manages client referrals and needs support?
Where is this data stored?
Data Quality and Security:
What procedures are in place to ensure data accuracy and completeness?
How is data security and confidentiality maintained?
Who is responsible for data quality and security?
Reporting and Outcomes:
What reports are generated, and how often?
What data is used for reporting?
Who generates the reports?
Who receives the reports?
Data Storage and Archiving:
How long is data stored?
Where is data archived?
What are the procedures for data disposal?

- THV Question: Exhibit G Section V. O/Section V.P

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☐ Activity 2: Building Your Data Story

- For your application, you'll need to translate your data flow into a narrative. Read our example, paying attention to the different parts of the data flow. Like in previous modules, we are using a fictional organization (Happy Stars) as an example.

Happy Stars prioritizes data tracking across all stages of the program. Potential participants are screened using our program tool, with results documented in our secure electronic database. This ensures consistent application of eligibility criteria and provides an auditable record.

Enrolled families receive thorough assessments using validated tools, including the ones mandated by our home visiting program model. These assessments are conducted by trained home visitors, and the data is directly entered into our database during the visit to minimize errors and ensure timeliness.

Home visitors document each interaction with families, including services provided, progress towards goals and any identified needs, within our database. This system allows for detailed case notes and visit summaries.

When a family need is identified, home visitors record this in our database and initiate a referral to appropriate community resources. We track the referral status, services received and any barriers to access within the system, enabling us to monitor the effectiveness of our support and identify gaps in community services.

Individualized family goals are established in collaboration with the family and are tracked within our database. Home visitors regularly update progress towards these goals, and this information is used to inform service planning and adjust interventions as needed. Reports generated from our database provide a clear picture of goal attainment and overall program impact.

This approach ensures that data is collected, stored and utilized effectively for our program at Happy Stars.

Reflection Questions:

What would you add to this narrative to improve its effectiveness in communicating Happy Stars' commitment to data tracking? ________

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How effectively does your current (or planned) data system integrate the tracking of screening, assessment, documentation, needs support and service goals? Are there any gaps? ________________

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Try it Out!

Ready to get started on your narrative? Use this outline as a guide for your writing.

I. Introduction

Purpose: To demonstrate a commitment to data tracking.

Key Elements:

- Emphasize the importance of data tracking across all stages of service delivery.
- State that data tracking is comprehensive and coordinated.

II. Screening

Purpose: To describe the process for screening potential participants.

Key Elements:

- Name of screening tool
- Where results are documented
- Explain how this ensures consistent application of eligibility criteria
- Explain how this provides an auditable record

III. Assessment

Purpose: To describe the assessment process for enrolled families.

Key Elements:

- Describe the assessment process
- Name of assessment tools

- Explain who conducts assessments
- Explain where data is entered and why

IV. Documentation

Purpose: To describe how interactions with families are documented.

Key Elements:

- Describe what is documented
- Explain where it is documented
- Describe what the system allows for

V. Needs Support Tracking

Purpose: To describe how needs and referrals are tracked.

Key Elements:

- Describe how needs are recorded
- Explain the referral process
- Describe what information is tracked
- Explain why this information is tracked

VI. Service Goal Tracking

Purpose: To describe how family goals and progress are tracked.

Key Elements:

- Describe how goals are established
- Explain where goals are tracked
- Explain how progress is updated
- Explain how this information is used
- Explain what reports show

VII. Conclusion

Purpose: To summarize how data is used in the program.

Key Elements:

- Summarize how data is collected
- Summarize how data is stored
- Summarize how data is utilized

- THV Question: Exhibit G Section V.O / Section V.P

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Client Service & Program Implementation | 8.2

Learning Objective: Participants will be able to explain their organization's procedures for determining client status, including intake, managing case closures and documenting any approved service changes.

Having a plan is a must for any successful home visiting program. This section focuses on the critical aspects of client service and program implementation, demonstrating your organization's ability to provide high-quality, effective home visiting services. This means having well-defined procedures for managing client cases, ensuring smooth transitions and adapting to changing needs.

☐ Activity 1: Your Client's Journey from Enrollment to Graduation

To effectively demonstrate your client service procedures, it's essential to visualize the client's journey through your program. In this activity, we'll map out the client's experience from enrollment to graduation, focusing on the key decision points, goal setting and transitions.

Step 1: Identifying Your Clients

- Complete this diagram of the different screening tools your program uses during intake and service of clients.

Example: "HV Program Mandated Survey" **Purpose:** Determine family goals	**Example:** **Purpose:**
Example: **Purpose:**	**Example:** **Purpose:**
Example: **Purpose:**	**Example:** **Purpose:**
Example: **Purpose:**	**Example:** **Purpose:**

Example:	Example:
Purpose:	Purpose:

*Note: You may have more (or fewer) tools than the spaces provided above; make sure you list all intake and service tools and assessments when you fill out your THV application.

Step 2: Identifying Basic Needs Support

- Basic needs support is an important part of your client's journey. Read this explanation of the basic needs support our fictional Happy Stars organization provides. Highlight or underline any areas that deal with **family assessment, types of support provided, costs** and **documentation and tracking.**

At Happy Stars, we assess family needs through a multi-faceted approach. Initially, home visitors use tools like the "Families in Need Assessment Tool" to identify needs such as food security, housing stability, transportation and childcare. Home visitors are trained to conduct these assessments with cultural sensitivity, building rapport for open communication. Ongoing needs are identified during home visits and through family self-identification via regular check-ins.

We offer various support services, including referrals to community resources (for example, "Helping Hands Food Bank," "Safe Harbor Housing") and information/advocacy to help families access services. Limited direct financial assistance is available for critical needs like rent, utilities or transportation. Support for families will range from $250 to $750, with a maximum of $1500 per family, prioritizing crisis situations. We also provide short-term support with diapers and baby formula.

All assistance is documented in our client database, including date, type, amount and referral outcomes. Home visitors ensure accurate, timely data entry after each home visit. We evaluate this data monthly to monitor support given, identify trends and evaluate effectiveness.

Now, let's compare your own program's basic needs support to that of Happy Stars.

	Happy Stars	Your Program
How are families assessed?	"Families in Need Assessment Tool"; by Home Visitors	
What type of support is offered?	referrals to community resources; information/advocacy; limited direct financial assistance	
What is the projected cost of support?	$250 to $750, with a maximum of $1500 per family	
How is the assistance tracked and documented?	in database after each home visit; data evaluated monthly	

Try it Out!

Use this outline to guide your own Basic Needs Support narrative.

I. Introduction: Needs Assessment Approach

Purpose: To describe your organization's approach to proactively assessing family needs.

Key Elements:

- State that your organization proactively assesses family needs.
- Describe the methods used for needs assessment.

II. Support Services Provided

Purpose: To detail the support services offered to families.

Key Elements:

- Describe the types of support services offered, like referrals and/or direct assistance.
- Provide examples of community resources for referrals.
- Explain any direct financial assistance, including amounts, limitations and priorities.

III. Documentation and Evaluation

Purpose: To explain how assistance is documented and evaluated.

Key Elements:

- Describe where and how assistance is documented.
- Explain the process for data entry and who is responsible.
- Describe how the data is used.

Step 3: Setting Goals

- Goals are crucial to a family's success in your program. Read this narrative of the goal-setting process our fictional Happy Stars organization utilizes. Highlight or underline any areas that deal with **how goals are determined, documented** and **tracked.**

Happy Stars' approach to goal setting is family-centered, strengths-based and tailored to each family's unique needs and aspirations.

Following enrollment, our home visitor establishes a collaborative relationship with the family and conducts a comprehensive assessment, including the "Family Needs Assessment Tool", to understand their strengths, needs and challenges. We evaluate several areas, including food security, housing stability transportation, childcare and overall family well-being. Through this assessment process we are able to collect data collection and build trust with the family.

Based on this assessment, our home visitors work in partnership with the family to develop individualized SMART goals. These types of goals are:

- **Specific:** Goals are clearly defined, outlining what the family wants to achieve.
- **Measurable:** Goals are formulated so that progress can be tracked and evaluated.
- **Achievable:** Goals are realistic and attainable within a reasonable timeframe, given the family's circumstances and resources.
- **Relevant:** Goals align with the family's overall needs and the program's objectives.
- **Time-bound:** Goals have a target date for completion.

This ensures that the family's priorities, needs and aspirations are central to the process. While our home visitors may offer suggestions and resources, the family holds the decision-making power in selecting their goals.

Once goals are established, our home visitors and the family work together to develop a service plan that outlines the steps and interventions needed to achieve those goals. This plan includes home visiting activities and curriculum components, referrals to community resources, strategies for addressing barriers, timelines and, finally, the identification of individuals or agencies responsible for providing support. The service plan is documented in our client database.

Home visitors will monitor the family's progress toward their goals during home visits. This involves tracking action steps, assessing intervention effectiveness, identifying emerging barriers, adjusting the plan in collaboration with the family and, of course, celebrating successes. Progress is documented in our database. This ongoing tracking enables data-driven decision-making and ensures that services adapt to the family's evolving needs.

Our home visitors and the family formally review goal progress every three months. During these reviews, they assess goal achievement and the need for modifications or new goals. Any updates or revisions are documented in our database.

Through this collaborative and ongoing process, Happy Stars empowers families to identify their own goals, take ownership of their progress and achieve lasting self-sufficiency.

Now, let's compare your own program's goal-setting process to that of Happy Stars.

	Happy Stars	Your Program
How are goals determined?	After initial assessment; following SMART format; with home visitor	
How are goals documented?	monitored by home visitors; in database	
How are goals tracked?	reviewed every three months with family	

Try it Out!

Use this outline to guide your own Goal-Setting narrative:

I. Introduction: Approach to Goal Setting

Purpose: To describe your organization's overall philosophy and approach to goal setting with families.

Key Elements:

- State if the approach is family-centered, strengths-based and tailored to individual needs.
- State any other important aspects of your organization's approach to goal setting.

II. Initial Assessment and Relationship Building

Purpose: To describe the process of establishing a relationship with the family and conducting the initial assessment.

Key Elements:

- Describe how staff establish a collaborative relationship.
- Describe the components of the comprehensive assessment.
- Name any specific assessment tools used.
- Explain the purpose of the assessment (data collection and trust-building)

III. Description of SMART Goals (Optional)

Purpose: To define and describe the SMART goal framework.

Key Elements:

- Describe what SMART stands for and how it applies to your families' goal-setting.
- Explain why this framework is used.
  *Note: If your organization does not use the SMART framework, it is still recommended that you include a description of how goals are written and set for your families.

IV. Family-Driven Goal Setting

Purpose: To emphasize the family's role in the goal-setting process.

Key Elements:

- Explain how your organization frames the goal-setting process around the family and their input.

V. Service Plan Development

Purpose: To describe the development of the service plan.

Key Elements:

- Describe who develops the service plan.
- Outline what the plan could possibly include:
  - Steps and interventions
  - Home visiting activities
  - Referrals
  - Strategies for addressing barriers
  - Timelines
  - Responsibilities
- State where the plan is documented.

VI. Ongoing Monitoring and Support

Purpose: To describe the ongoing process of monitoring and supporting families in achieving their goals.

Key Elements:

- Describe how staff monitor progress.
- List what monitoring involves:
  - Tracking action steps
  - Assessing intervention effectiveness
  - Identifying barriers
  - Adjusting the plan
  - Celebrating successes
- State where progress is documented.
- Explain how tracking informs decision-making.

VII. Formal Review Process

Purpose: To describe the formal review process for goal progress.

Key Elements:

- Describe the frequency of formal reviews.
- Describe what happens during reviews.
- State where updates/revisions are documented.

VIII. Conclusion: Empowerment and Self-Sufficiency

Purpose: To summarize the overall outcome of the goal-setting process.

Key Elements:

- Emphasize family empowerment.
- Highlight the achievement of self-sufficiency.

Step 4 (Optional): Changing the Program Model

Your organization and the families you serve are unique. As such, your prescribed home visiting program model may require changes or adaptations to best suit your capacity and the needs of your community. It's important to note that all approved program models in Texas have specific requirements, and applicants must ensure they are fully aware of and adhere to these. However, if your program model allows for adaptations, these should be clearly described in your THV application, explaining how they will enhance services for your community. Use these questions as a guide for how you will communicate these changes in your THV application.

1. Does your organization plan to implement the evidence-based program with any variations from the original model? If so, what are they?
2. Are these variations related to content, delivery methods or other aspects of the program?
3. Have any of the variations been previously approved by the program developer?
4. If variations are planned but not yet approved, is the agency seeking approval from the program developer? What is the timeline for this process?
5. What is the rationale for any planned variations?
6. How do these variations address the specific needs of your community?
7. Does your organization plan to incorporate virtual service delivery as part of the program implementation?

Step 5: Finishing the Journey

- The ultimate goal of any program is to see families finish their home visiting journey. Read this text that narrates how our fictional Happy Stars organization determines service completion. Highlight or underline any areas that deal with **processes and procedures for case closure, referrals** and **follow-up.**

At Happy Stars, we have a comprehensive process for determining service completion, managing case closure and ensuring appropriate referrals and follow-up to support families' ongoing success.

Service completion is determined through a collaborative process between the home visitor and the family. This determination is based on the achievement of established goals and the family's demonstrated capacity to maintain progress independently. Several factors contribute to this decision. Primarily, we look at the extent to which the family has achieved the goals outlined in their individualized service plan, which is assessed through ongoing monitoring and regular review of progress, documented in our database. Home visitors also assess the family's ability to independently access and utilize community resources, problem-solve and advocate for their needs. We also ensure that the family has achieved stability in key areas such as housing, income and childcare. The home visitor provides a professional recommendation, based on their ongoing assessment of the family's progress and capacity, and importantly, the family concurs with the decision that services are no longer needed and they are comfortable with case closure.

Once service completion is determined, we follow specific procedures for case closure. The home visitor and family collaboratively develop a closure plan. This plan summarizes the services provided, the progress made and the strategies the family will use to maintain their progress. It also identifies any remaining needs and outlines a plan for addressing them. The home visitor completes all necessary documentation in our database, including a final progress note, a summary of services provided and the closure plan. To ensure that all procedures have been followed and that the family's needs have been adequately addressed, the home visitor's supervisor reviews and approves the case closure. Finally, the family is provided with a formal written notification of case closure, including contact information for Happy Stars and relevant community resources.

Referrals and follow-up are integral components of our service delivery model, both during and after active service provision. Throughout the duration of services, home visitors make referrals to community resources as needed to address families' identified needs. These referrals include agencies providing food assistance, housing support, childcare, mental health services and other essential support. At the time of case closure, families are provided with a comprehensive list of community resources that can provide ongoing support, and the closure plan specifies which resources the family is connected to. Happy Stars also has a flexible follow-up process. At a minimum, home visitors will attempt to contact families, typically 3- and 6-months post-closure, to assess their continued progress and identify any emerging needs. The method and frequency of follow-up can be adjusted based on the family's preferences and risk level. If needed, families are re-connected to community resources. Follow-up contacts and outcomes are documented in our database to monitor the long-term effectiveness of our services and inform program improvement efforts.

1. How does your organization define service completion? What specific criteria are used?
____
____

2. What are the steps involved in case closure at your organization? ______________
____

3. How does your organization determine the need for referrals during service provision? What are some common referral sources? ________________________________
____

4. What are the key similarities and differences between your agency's processes and those described in the narrative? ______________________________________
____

Try it Out!

Use this outline to guide your Case Completion narrative:

I. Introduction: Approach to Service Completion and Case Closure

Purpose: To introduce your organization's overall approach.

Key Elements:

- List the key components: service completion, case closure, referrals and follow-up.
- Emphasize the goal of supporting families' ongoing success.

II. Determining Service Completion

Purpose: To describe the process for determining when services are complete.

Key Elements:

- Explain how it is determined between staff and family that services are complete.
  - List the factors considered, like achievement of goals, family's capacity to maintain progress independently, ability to access and utilize community resources, problem-solving and advocacy skills, stability in key areas, staff recommendation and/or family agreement.
- State where progress is documented.

III. Case Closure Procedures

Purpose: To describe the procedures followed once service completion is determined.

Key Elements:

- Explain the specific procedures for case closure.
- Describe the development of a closure plan:
  - Summary of services provided
  - Summary of progress made
  - Strategies for maintaining progress
  - Identification of remaining needs
  - Plan for addressing remaining needs
  - Referrals to community resources
- Describe the documentation process.
- Describe the review and approval process.
- Describe the family notification process.

IV. Referrals and Follow-Up

Purpose: To describe the organization's approach to referrals and follow-up.

Key Elements:

- Explain how referrals and follow-up are integral components.
- Describe the referral process during service provision.
- Describe the resources families are referred to.
- Describe the resources provided at case closure.
- Describe the follow-up process.
- State where follow-up is documented.

THV Question: Exhibit G Section V.Q / Section V.H / Section V.I / Section V.J / Section VI.B ____________________

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Reporting & Compliance | 8.3

Learning Objective: Participants will be able to articulate their understanding of and capacity to fulfill all required state reporting obligations, including PEIRS data entry and quarterly reports.

In Section 8.1 of this Module, you built out your organization's data flow and tracking procedures. Remember, these procedures are instrumental in demonstrating your organization's ability to meet all reporting and compliance requirements. Now, we will take a closer look at a crucial part of state reporting: PEIRS data entry.

PEIRS, or the Prevention and Early Intervention Reporting System, is a statewide database used by Texas home visiting programs to collect and report participant-level data to the Texas Health and Human Services Commission (HHSC). It contains detailed information about enrolled families, services provided and outcomes achieved. Accurate and timely PEIRS data entry is essential for program accountability, funding and quality improvement.

Here are some key things you should know about PEIRS:

- **Data Requirements:** PEIRS requires detailed data on family demographics, risk factors, services delivered and progress towards program goals. This data is used to track program performance and ensure compliance with state and federal guidelines.
- **Reporting Frequency:** Home visiting programs are typically required to submit PEIRS data monthly/quarterly. Reports provide a snapshot of activities and outcomes.
- **Data Quality:** Maintaining data accuracy and completeness in PEIRS is critical. Programs must have systems in place to ensure data is collected and entered correctly.
- **Confidentiality:** PEIRS data contains sensitive information about families and must be handled with strict confidentiality. Programs must adhere to all privacy laws and regulations.
- **Training and Support:** The Texas HHSC provides training and support to home visiting programs on PEIRS data entry and reporting. Programs should ensure their staff are adequately trained.

Why is it important to understand PEIRS?

1. **Application Alignment and Readiness:** Your THV application must demonstrate a clear understanding of how your data tracking system aligns with PEIRS requirements. This alignment signifies your program's readiness to meet the rigorous data reporting standards set by the state.
2. **Program Compliance and Accountability:** For programs awarded THV funding, adherence to PEIRS is not optional. PEIRS serves as the primary mechanism for demonstrating program accountability. Accurate and timely data entry into PEIRS is essential for maintaining compliance with state regulations, securing continued funding and fulfilling reporting obligations.
3. **Data-Driven Program Improvement:** Beyond compliance, PEIRS data provides invaluable insights that can be used to enhance program effectiveness and improve outcomes for families. By analyzing PEIRS data, programs can identify trends, track progress toward goals and pinpoint areas where services may need to be adjusted or strengthened.
4. **Advocacy and System-Level Change:** PEIRS data provides a powerful tool for advocating for increased funding and improved policies that support home visiting services in Texas. By demonstrating the collective impact of home visiting programs on key outcomes, like maternal and child health, school readiness or family stability, the home visiting community can make a compelling case for greater investment in these vital services.

Bonus:

Want to dive deeper into PEIRS? Check out these webinars from HHSC.

https://fss.hhs.texas.gov/Grantees/video_training/evaluation_and_data.asp